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Chapter Eleven: Nietzsche and the Right to Die: A Critical Dialectic of Access to Euthanasia or Medical Aid in Dying

Introduction

> Morality for doctors. Sick people are parasites on society. It is indecent to keep living in a certain state. There should be profound social contempt for the practice of vegetating in cowardly dependence on doctors and practitioners after the meaning of life, the right to life, is gone. Doctors, for their part, would be the agents of this contempt – not offering prescriptions, but instead a daily dose of disgust at their patients … To create a new sense of responsibility for doctors in all cases where the highest interests of life, of *ascending* life, demand that degenerate life be ruthlessly pushed down and thrown aside … Dying proudly when it is no longer feasible to live proudly.
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> (Nietzsche, 1983)

> Morality for doctors. … Death chosen freely, death at the right time, carried out with lucidity and cheerfulness, surrounded by children and witnesses: this makes it possible to have a real leave-taking where the leave-taker is still there, and a real assessment of everything that has been achieved or willed, a summation of life – all in contrast to the pathetic and horrible comedy that Christianity stages around the hour of death.
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> (Nietzsche, 1983)

In this chapter, I undertake a theoretical examination of the issues that the province of Quebec's euthanasia legislation, Medical Aid in Dying (MAID), raise for end-of-life nursing. I employ a critical dialectic approach that involves iteration and the synthesis of a thesis based on studies of legal euthanasia, and an antithesis constructed from Nietzschean concepts and positions.

Medical aid in dying may seem to be a straightforward medical intervention to provide relief to people experiencing unbearable suffering at the end of life. However, as implemented in Quebec, the practice is to be governed by a purely normative deontology patterned on laws in Europe, where the contexts and practice of medicine and nursing are vastly different. Given the particularly instrumentalized healthcare environment in Quebec, breaches of professional conduct are liable to occur. In Quebec and in most of North America, healthcare

systems have been compelled to adopt unprecedented measures of austerity, bureaucratization, technocratization, and commodification (Betts, 2005; Krol & Lavoie, 2014). These oppressive systems, as Nietzsche foresaw (1971) over a century ago, have given rise to the reification of the human body and spirit as a locus for domination and experimentation inspired by the cult of progress and governed by hegemonic narratives of pure logic and of control both physical and mental. As Nietzsche wrote:

> Hubris today characterizes our whole attitude towards nature, our rape of nature with the help of machines and the completely unscrupulous inventiveness of technicians and engineers; hubris characterizes our attitude to God, or rather to some alleged spider of purpose and ethics lurking behind the great spider's web of causality … hubris characterizes our attitude towards ourselves – for we experiment on ourselves in a way we would never allow on animals, we merrily vivisect our souls out of curiosity: that is how much we care about the "salvation" of the soul! Afterwards we heal ourselves: being ill is instructive, we do not doubt, more instructive than being well […]. (Nietzsche, 1979)

Employing a critical dialectical method, I suggest that our sanitary systems comprising an oppressive organization (i. e., some of the settings in which euthanasia is to be performed) and reifying actors (some of the professionals who may carry it out) will overwhelm the practice of MAID. In other words, it will succumb to the pressures of austerity and instrumentality brought to bear by modern narratives of the sanitary systems, provoking breaches of deontology – and thus of practice – with potentially disastrous results for the end-of-life experience.

The following discussion begins with a brief outline of the dialectical method, a digest of current euthanasia practice in jurisdictions where it has been legalized, and a summary of Quebec's recent legislation on the matter. I then utilize the Nietzschean concepts of "alterity," "ipseity," "will to power" and the "ethic of life" to develop a critical dialectic regarding issues likely to arise in the practice of MAID in Quebec.

Dialectics, Critical Theory, and Emancipation

A critical theoretical approach in the social sciences entails examining the structural conditions of human existence in order to produce knowledge to help free the oppressed and improve their conditions of life (Chinn & Kramer, 2014; Denzin & Lincoln, 2011, p. 102, p. 55; Schwandt, 2007). Lincoln et al. recommend using the dialectical method in applying critical theory. From Krol and Lavoie's (2015) Marxist dialectical perspective, this method involves constructing two opposing arguments – a thesis and an antithesis – about a topic (in

this case aspects of euthanasia) and employing a deconstructionist critical approach to analyze the opposition between them and elicit a synthesis that would produce emancipatory substance and movement – that is, praxis (in this case, for nursing theory and practice).

I begin by developing my thesis based on a deconstructionist reading of legal and empirical studies on the practice of euthanasia in jurisdictions where it is lawful, and by an examination of Quebec legal documents. My antithesis draws on selected Nietzschean positions, concepts, writings, and aphorisms to formulate a radical, critical argument that stands in sharp contrast to the practice of MAID that has been advanced in Quebec.

The epistemic foundations of the deconstructionist approach used here lie in post-structuralism (Malpas & Wake, 2006). Deconstruction of empirical studies or legal documents involves bringing to light the meanings, structures, syntax, language, and actors behind the text, the instrumental rhetoric, and narratives about euthanasia. Texts are thus subjected to continual examination (dissection, criticism, evaluation) to reveal hidden meanings and agendas, dissect preconceptions, explore modern biases, and expose the influence of particular values by successively highlighting points of conflict and even sparking crises and controversies. Conflicts of this sort fuel the dialectic between the thesis of what is to all appearances an instrumental practice and the Nietzschean antithesis of an ethic of life; authentic choice at the end of life based on the concepts of ipseity, alterity, and the will to power.

The dialectic is, furthermore, grounded in a critical ontic perspective from which the world is conceived as the interplay of forces of domination and power (Lincoln et al., 2011). This perspective, according to which historic phenomena are interpreted in terms of a struggle for strength, organization, and domination, is thus in keeping with the central Nietzschean concept of the will to power. In the interests of internal consistency and rigour, the critical dialectic is also founded on an epistemic approach strongly inspired by values of social justice, emancipation, (Lincoln et al., 2011) and Nietzsche's ethic of life.

The discussion here is not an empirical, "objective" enterprise that has been stripped of political values or a political stance. On the contrary, the purpose of my synthesis, the crux of this critical-theory approach, is to expose and challenge the organization, language, and actors that hold in their hands the power to dominate and oppress the ill, the dying. In addition, my political engagement entails constructing and proposing clear methods to keep people at the end of life from being subjugated to a single hegemonic "reality," to a deontological sanitized biomedical prerogative subverting the practice of assisted death in Quebec.

The Practice of Euthanasia

This section summarizes the empirical nursing literature on issues and processes involved in euthanasia practice in jurisdictions where it has been legalized over the past few decades. The review will serve to provide the argument of the thesis for a critical dialectic regarding the introduction of MAID in Quebec.

Published studies on euthanasia in some of the countries where it is legal practice (Netherlands, Belgium, and the state of Oregon in the US) have found that fewer than half the official requests for the procedure by pre-terminal patients living with extreme suffering are actually granted. Most are rejected by medical authority (Pasman, Willems & Onwuteaka-Philipsen, 2013, p. 313), who prefer providing additional, often futile – though purportedly palliative – treatment or who categorically refuse to perform euthanasia on religious or moral grounds. In a smaller number of cases, patients who apply do not follow through with the process. In almost every case though, the medical decision, which is fundamentally deontological in nature, weighs "heavily" on the attending physician, usually a general practitioner (Georges, The, Onwuteaka-Philipsen, & van der Wal, 2008, p. 151). Refusals often stir negative emotions in physicians, including guilt and withdrawal, and may even lead to anti-professional authoritarian and avoidance behaviour (Dees, Vernooij-Dassen, Dekkers, Elwyn, Vissers, & Weel, 2013, p. 32). Among nurses providing end-of-life care, many of whom favour euthanasia, refusals also have negative effects, ranging from a sense of professional impotence to self-deprecation (de Bal, de Casterlé, de Deer, & Gastmans, 2006, p. 593).

Once euthanasia has been prescribed for a patient who has necessarily met all the requirements in accordance with the ethical standards in a given jurisdiction, a process gets underway, gathers momentum, and culminates rather quickly in ending the suffering of the patient as well as of the family; sometimes the healthcare professionals involved too find relief (Norwood, Kimsma, & Battin, 2009, p. 477).

A number of studies document the steps that the interventions must follow. They outline a complex, dynamic, relational process comprising a specific sequence of overlapping stages (de Casterlé, Denier, de Bal, & Gastmans, 2010; Dees, et al., 2013; Denier, de Casterlé, & Gastmans, 2010). Some research suggests that the process must, as far as possible, be procedurally oriented and fact based (Denier et al, 2010; van Bruchem-van de Scheur et al., 2008). It must consequently comply – that is, submit completely – with the deontological prerogatives *per se*. The purportedly "right" actions must thus be taken at the "right" time with the "right" people in the light of what is deemed "right" in the strict meaning of the law – as determined, of course, by the medical authority concerned. While a general process guiding euthanasia can be mapped out, the

studies indicate the existence of fine procedural and deontological distinctions stemming mainly from political and socio-cultural variations between jurisdictions. Euthanasia processes thus vary by country or state. For example, in the Netherlands, general practitioners regularly make home visits and follow up scrupulously by telephone with patients at the end of life (Norwood et al., 2009, p. 475).

As noted, the process depends fundamentally on the patient, nurse, and physician engaging in an open dialogue and deliberating jointly (Norwood et al., 2009; van Bruchem-van de Scheur et al., 2008) on how to organize care in the period before euthanasia (Denier et al., 2010). By the same token, the process necessitates creating and maintaining an organized dynamic, a momentum, to ensure continuity of care and fulfilment of the outcome (Norwood et al., 2009). This momentum should most especially and as far as possible channel decision-making towards ending the individual's suffering with dignity (de Bal et al., 2006, p. 597). It also entails reaching an agreement that generally should favour and respect the autonomy of the person concerned in deciding the time and place for the euthanasia (de Bal et al., 2006). However, it is often unfortunately the case that the process is impeded at various levels of modern sanitary systems by an exacting and opaque bureaucracy and by the paternalistic attitudes of physicians opposed to the practice (de Bal et al., 2006, p. 595). Furthermore, Pasman et al. (2013) show that patients may abandon their request if they feel they are imposing a further burden on already overworked nurses. The issues and problems encountered in Europe – the subjection of euthanasia to a medical authority, the instrumental deontology, bureaucratic impediments, geographic and political variation, the need for process and momentum – raise fears that the practice of MAID in Quebec will be affected in a similar and possibly even worse fashion.

This, then, is the argument of my thesis regarding euthanasia as it is practised internationally. I shall now turn to a discussion of the elements of the Nietzschean argument that form my antithesis and then proceed to the dialectic proper.

Nietzschean concepts

The will to power

> [Anything which] is a living and not a dying body… will have to be an incarnate will to power, it will strive to grow, spread, seize, become predominant – not from any morality or immorality but because it is living and because life simply is will to power…

> "Exploration"… belongs to the essence of what lives, as a basic organic function; it is a consequence of the will to power, which is after all the will to life. (Nietzsche, 1987)

Nietzsche's notion of will, Heidegger (1954) explained, refers to the volition to control and command, and especially, insofar as it is possible, to freely express the choice to strive towards strength and structure in accordance with a sorted – yet moving – hierarchy of values; hence, the fundamentally ethical nature of will. It stems from a perception of a lack or a void and stimulates a constant struggle towards power, which (like health) can never be fully attained. Power is the expression of the accumulation of strength, structure, and authority. Thus, for Nietzsche, the will to power, as an ontic process, constitutes the very essence of that which animates the world. Everywhere, in every space, there are only these power relations, relations of will to power (Montebello, 2001). More particularly, the will to power gives impetus to the direction of force, resulting in the perpetual movement that allows structure to endure and animates life.

Ipseity

Influenced by biological theorists of his day, such as Wilhem Roux and Rudolf Virchow, Nietzsche developed the notion of an ethic of life animated by the will to power (Montebello, 2001) and modulated by, among other things, ipseity and alterity, key concepts in his complex thinking (Stiegler, 2001). Nietzsche was truly inspired by Willam Roux's thesis on biological ipseity:

> The smallest organisms go very far in their assimilation of the new – the unknown – to their own: no one is more resistant to the diversity of external powers than the protoplasm, and on the other hand, no one is more sensible to alterations from the outside and the alterity as a whole, than the complex organism fighting to preserve its own identity and become itself. (Stiegler, 2001, p. 37, my translation)

Ipseity is the property that defines the very nature of things, the essence that colours their uniqueness and distinguishes them from other things (Lalande, 2007). Ipseity refers to that which is naturally and biologically specific to living organisms and makes their cohesion and cell survival possible. For Nietzsche, ipseity constitutes an immanent force that stimulates structures to endure and thus promotes the survival, growth, and fulfilment of a unified self (Stiegler, 2001). The self is conceived as a cellular "we" animated by the will to power, by the forces of ipseity and alterity actuated by an ethic of life. Viewed in terms of the will to power, ipseity constitutes an emancipatory, structuring, creative process; it fosters a constellation of forces of growth and fulfils a basic function in the realization of life's potential. However, it is also a force that animates recognition and screening, the rejection of and struggle against everything that

is other, principally, though not solely, the force of alterity and its potentially harmful processes.

Alterity

Alterity, the property that refers to everything that is other to the self, is the opposite of, and, at the same time, a necessary complement to ipseity. Viewed in relation to the will to power, alterity is also an immanent force of aggression emerging from both within and without the self and essential to mobilizing and maintaining the structure of, and struggle for, life (Stiegler, 2001). As an aggressive force emanating from the not-self, alterity stimulates and provokes life to constantly (re)build. As a potentially fatal force emanating from within, or "permanent suicide," in Nietzsche's view, the function of alterity is to seek by all means possible to change the physiological structure of life in order to destroy it. Indeed, "here it is important to defy all the cowardice of prejudice and to establish, above all, the real, that is, the physiological, appreciation of so-called natural death – which is in the end also 'unnatural,' a kind of suicide" (Nietzsche, 1983, p. 36). Thus, as Stiegler points out, the process by which alterity is recognized – namely, ipseity – protects life from the unknown, from danger, disintegration, and death. However, life's mechanisms for evolution and resistance are limited by nature; alterity cannot be perpetually kept at bay. Like ipseity it plays a role in regulating the evolution and adaptation of living beings.

The ethic of life

For Nietzsche, as Stiegler (2001) put it, the ethic of life is animated by the will to a natural life, structured by the will to power and modulated, though not solely, by forces of alterity and ipseity. It is a basic premise of Nietzsche's philosophy that the ethic of life is a natural conation, and given the assumption that life is not an exclusively human function, he espouses an anti-anthropocentric orientation. Nietzsche thus condemns modern man's delusional worship of progress and celebrates the return of natural man. Furthermore, from the ontic perspective of the will to power, that which contributes to power, contributes to life. As an ethical volition, Nietzsche's ethic of life fosters the structuring and natural fulfilment of the organisms it animates.

For Nietzsche (1989), the ethic of life thus signifies expressing one's conation to realize and surpass oneself by employing the natural possibilities offered by the present while aspiring to a future in continual becoming. Given the uncertainty of life's duration and integrity, the active quest for structure and power is a constant of existence. Thus, life perpetually creates itself; it simply cannot remain a static phenomenon. This creative function, this "wasteful and indif-

ferent magnificence" (Nietzsche, 1971b), drives the continuous transformation of life. It may consequently surpass alterity and generate a sense of power and freedom that in turn support its structured growth (Reginster, 2006). In this Nietzschean ethic, life is worth living freely and creatively.

Dialectic about Medical Aid in Dying

In 2009 a select committee of Quebec's National Assembly was formed to consider the thorny deontological and legal issues that would arise out of the eventual legalization of euthanasia. After numerous consultations over the following two years, it published a report in 2012 entitled *Dying with Dignity*, which made recommendations on "end-of-life care" and "medical aid in dying." A bill on end-of-life care was consequently introduced with the stated aim of meeting the Quebec public's demands to "democratize," as it were, the quality of, and access to, palliative care and euthanasia. The main purpose was to improve the quality of existence at the end of life through the relief of suffering, palliative sedation, and (in an eminently politically correct formulation), medical aid in dying. Bill 2 came into force in December 2015 with the establishment of a special committee to oversee its implementation and to monitor outcomes and possible infringements.

The oppressive organization

The analysis of the studies presented above suggests conducting a critical dialectic on two levels: those of the oppressive organization (the sanitary systems) and the reifying actor (the medical authority).

> Major ER overcrowding as a daily reality, rising costs for medication, aging of the population, deinstitutionalization of primary care services, nursing shortages, low investments in infrastructure and sanitary systems management, retrieval or home care services : all these are ingredients of a major crisis which could cause the implosion of the system and put in danger accessibility. (Jetté, 2008, p.1, my translation)

> The New Idol. Somewhere there are still peoples and herds, but not with us, my brothers: here there are states. A state? What is that? Well! open now your ears to me, for now will I say to you my word concerning the death of peoples. State is the name of the coldest of all cold monsters. Coldly lies it also; and this lie creeps from its mouth: "I, the state, am the people." It is a lie! Creators were they who created peoples, and hung a faith and a love over them: thus they served life. Destroyers are they who lay traps for many, and call it the state: they hang a sword and a hundred cravings over them. (Nietzsche, 1985)

Quebec's sanitary system has deteriorated sharply over the years (Jetté, 2008). The once-celebrated, socially prosperous legacy of the Canadian welfare state has undergone change after change since the mid-1970s. It has suffered from deinstitutionalization, commodification of services, and the damaging depletion of resources. It has been subjected to discourses of austerity, neo-liberalism, "excellence," "best practices," and more recently, to an interfering biomedical despotism that has ramified through the provincial government to the detriment of accessibility and quality of care. Studies in Quebec and North America as a whole reveal a situation in which the instrumentalization of sanitary systems goes hand in hand with an hierarchical autocracy. Medical authorities' hegemonic domination is thus sustained by narratives of efficiency, technocracy, bureaucracy, and productivity aimed at achieving standardization and systematic efficacy of mainly curative interventions (Beagan & Ells, 2009; Jetté, 2008; Krol & Lavoie, 2014; Whiteside, 2011). Studies also illustrate the manifest neoliberalism of the Quebec sanitary system: it is directive – even oppressive – and poorly accessible; numerous services have been chopped to a bare minimum and strict rules limit access. This post-welfare regime reflects concretely how far the state has retreated from its commitments to health care and allowed the mercantilist delusions of the private-sector narrative to shape deregulation (Jetté, 2008). The situation is overwhelming, and we face the spectre of end-of-life care and especially of MAID mirroring these shortcomings. It is therefore little short of utopian to imagine it possible to implement the process and momentum that, according to European studies, are necessary for the proper administration of euthanasia (de Bal et al., 2006, p. 597; Norwood et al., 2009). MAID is thus all too likely to be subjected to instrumentalization by distant, intractable organizations.

European studies reveal some of the recurrent organizational and bureaucratic impediments to the process and momentum required to make euthanasia a reality in Quebec. These impediments have the perverse effect of prolonging neglect and human suffering (De Bal et al., 2006). Most disgracefully, the actual operation of medical aid in dying in Quebec is bound, as in Europe, to hegemonic narratives of biomedical governance. Implementation will necessarily involve a bureaucratic organization of authoritarian, distant, complex, and impenetrable control, an organization of a type that, studies show, prolongs suffering and may even cause physical injuries (Abadia & Oviedo, 2009; Pannowitz, Glass, & Davies, 2009). The outlook for patients who request MAID in Quebec is thus grim, especially in light of the fact that the Quebec sanitary system already has trouble providing a minimum of fragmented, mainly curative services that are generally hard to access – if not simply nonexistent (Jetté, 2008).

Furthermore, empirical studies show that nurses and physicians in some palliative care settings are highly reluctant to perform euthanasia (de Bal et al.,

2006), even though patients in these facilities for "slow death" may be given ambiguously lethal treatments that verge on passive euthanasia. That said, the structural conditions cited – inaccessibility, bureaucracy, austerity, biomedical governance – are liable to create a situation in which MAID is forced to become a taboo "itinerant" practice conducted in inappropriate conditions far from the cheery pretentions of home care (Ganz & Musgrave, 2006; Thulesius, Scott, Helyesson, & Lynoe, 2013). Notwithstanding all the impediments and failings found to prevail in the oppressive organization of health care, the important thing, Nietzsche reminds us, is that people can still fulfil their potential for self-realization in a death they have freely chosen – thus sanctifying the forces of alterity – as they carry out their last wishes.

The reifying actors

> Morality for doctors. … Death chosen freely, death at the right time, carried out with lucidity and cheerfulness, surrounded by children and witnesses: this makes it possible to have a real leave-taking where the leave-taker is still there, and a real assessment of everything that has been achieved or willed, a summation of life – all in contrast to the pathetic and horrible comedy that Christianity stages around the hour of death. (Nietzsche, 1983)

> Over the last forty years, however, the death and dying discourse has changed. Paternalism is increasingly difficult to defend when treating competent patients and has eventually become a dysphemism, indicating an emergent taboo of questioning autonomy. (Thulesius et al, 2013, p. 12)

Quebec's Bill 2 lays out how the practice of MAID is to be organized and identifies the conditions that must be met and the medical treatments that may be prescribed for a person at the end of life. The legislation defines a person at end of life as one suffering from an incurable condition and experiencing advanced, irreversible decline of his or her physical (or mental) capacities. Exercising their competencies in compliance with their professional deontology, attending physicians must make a diagnosis that their patient is indeed experiencing "constant and unbearable physical or psychological suffering which cannot be relieved in a manner the patient deems tolerable" (Gouvernement du Québec, 2016). The provision of MAID consequently depends *per se* on a judgement exerted by medical authority; that is, prescribed by healthcare actors who are bound to their normative deontology of being unbiased and somehow stoic. However, the empirical literature shows clearly that such decisions are anything but free of bias.

Despite anything deontology in the various jurisdictions might suggest, a majority of physicians are reluctant to perform euthanasia because of their personal values or religious (principally Catholic) asceticism (Inghelbrecht,

Bilsen, Mortier, & Deliens, 2009; Jylhankangas, Smets, Cohen, Utrianen, & Deliens, 2014; Sercu, Pype, Christiaens, Derese, & Deveugele, 2011). Moreover, many attending physicians become paternalistic and authoritarian when dealing with and refusing a request for euthanasia (Dees et al., 2012; Thulesis et al., 2013). The prospect of authorizing death apparently upsets certain core values; it leads physicians to entrench themselves in their role, their position of power and domination, and to condemn – and delegitimize – these requests.

From a Nietzschean perspective, such a transgressional inconsequential deontology resembles nothing more than an insidious quest for biopower and domination over life and over the natural, vital forces of ipseity and alterity; a quest, indeed, for the biomedical and metaphysical subjugation of human life on the part of actors, who by all means possible, intend to maintain their authority and power over subjection of life and death. The person at the end of life is effectually stripped of his or her autonomy and freedom and is subjected body and soul to reifying actors making virtually totalitarian decisions on the basis of "legislated" scientific standards, positions, and treatment options.

These reifying actors, furthermore, exert their power in the name of arbitrary values metaphysically founded in Christianity. To Nietzsche, these values are among the most reprehensible, indeed contemptible, that can exist. From the perspective of his ethic of life:

> Morality for doctors. Sick people are parasites on society. It is indecent to keep living in a certain state. There should be profound social contempt for the practice of vegetating in cowardly dependence on doctors and practitioners after the meaning of life, the right to life, is gone. Doctors, for their part, would be the agents of this contempt – not offering prescriptions, but instead a daily dose of disgust at their patients … To create a new sense of responsibility for doctors in all cases where the highest interests of life […]. Dying proudly when it is no longer feasible to live proudly. (Nietzsche, 1983)

Nietzsche, who had been an army orderly, maintained that people who express a wish to end their distress should be allowed to carry out their free and final choice and be done with their suffering.

Careful reading of the empirical studies on assisted-death practice in other jurisdictions suggests that the diagnostic and ethical criteria set out in Quebec's Bill 2 are almost solely modelled on European legislation. While there are differences regarding diagnoses, a person requesting euthanasia must, as in some European countries, have a collaborative relationship with a physician. The request for assisted dying must be repeated over the course of several conversations with the doctor. Dialogue during these encounters should focus on informed consent regarding prognoses, palliative treatments, and the possible procedure for ending life. Quebec's healthcare systems, however, are dominated by an ultraconservative medical hierarchy that provides little room for dialogue.

Time, money, and resources are in short supply, and certain actors in this oppressive organization paternalistically impose decisions. If a trusting, authentic, close relationship between attending physicians and patients is as necessary as the international studies clearly indicate, it is hard to imagine a truly relational process for MAID developing in Quebec.

The "comedy that… has [been] made of the hour of death," as Nietzsche (1983) put it, is totally arbitrary, if not perverse, from the perspective of his ethic of life. Human life is ceaselessly interpreted through the effort to fulfil and surpass oneself, whether one seeks life or (ultimately) death. From this standpoint, it is essential we respect the free choice expressed by individuals suffering in body and soul. They should not have their existence and distress subjected to reifying actors, especially ones who exert arbitrary power based on ascetic metaphysical values and motivations that may upset, even prevail over, their commitment to a normative deontology. In the final analysis, Nietzsche's ethic of life demands that the natural values and forces of life be respected, so that people may fulfil the possibilities for life or for death that the present offers them.

Synthesis, Conclusion and Recommendations

My preceding discussion has offered a theoretical critique of the practice of euthanasia as a "biomedical, yet instrumental" treatment delivered in accordance with standards laid out by pure normative deontology. I described the sanitary systems and human issues involved and the consequences for the practice documented in empirical studies. I then undertook a dialectical speculation on issues raised by the more recent introduction of MAID in the dehumanized Quebec context. The preliminary conclusions are disheartening. I therefore suggest that MAID should be read in a radically different, a decidedly non-normative manner, and that the *text* on euthanasia should be rewritten; discussion should start from the premise that the right to die at the end of life is not a problem to be resolved by normative deontology but rather lived as a privilege, a natural phenomenon animated by the never-ending interplay of forces of alterity, ipseity, and the ethic of life.

I presented two arguments in relation to the oppressive organization and the reifying actors: the instrumental thesis and an antithesis grounded in the Nietzschean ethic of life. From the standpoint of my critical, emancipatory position, I conclude that people suffering at the end of life should be able to exercise much greater freedom to make their own decisions. More particularly, I suggest that people suffering at the end of life be given due respect when they express their last wishes and final decision about their body, their spirit, and their existence, provided their decisions are autonomous, informed, and con-

sidered. In accordance to Nietzsche's position on the "live" end of life, I argue that euthanasia should not be thought of as an easy "way out" for everyone suffering at the end of life, nor should it be "democratized" without appropriate supervision. My serious concern – and the reason for this dialectic – is that MAID is likely to be practised in oppressive healthcare organizations and subject to arbitrary biomedical despotism. In these circumstances, the prospective experience for anyone requesting aid in dying is liable to be grim indeed.

In light of the various issues one may encounter in MAID, I therefore maintain that consideration of Nietzsche's ethic of life will allow us to avoid conceiving end-of-life care from a strictly deontological perspective, but, in accordance with the Nietzschean argument, I approach it from the standpoint of immanent, natural (biological and physiological) life. The ethic of life allows us to reconnect with our inevitable frailty and fate as human beings. However, it also encourages us to give the ultimate expression to our self-determination and our freedom to live our life to the utmost and to die with dignity.

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